Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Physician Mgmt Svcs dba Injury 1 Trtmt Ctr

Respondent Name
The Insurance Company

MFDR Tracking Number
M4-13-2173-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
April 29, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claims are incorrectly denied. The claims were originally denied stating preauthorization was absent. The treatment was preauthorized and clearly noted on the claim form in box 23. Then, the claims were sent for reconsideration and they were denied as a duplicate..."

Amount in Dispute: $4,236.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received May 7, 2013. However, no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 17 – February 12 2013	97545, WH CA 97546, WH CA 96151	$4,236.00	$3,456.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out requirements for preauthorization, concurrent utilization review, and voluntary certification of health care.
3. 28 Texas Administrative Code §134.204 sets out medical fee guideline for specific workers' compensation services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 18 – Duplicate Claim/Service
   - 197 - Payment adjusted for absence of precert/preauth
   - 193 – Original payment decision maintained

Issues

1. Did the respondent comply with Division rules?
2. Did the requestor support additional requested payment amounts?
3. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on May 7, 2013. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.

2. The carrier denied the services in dispute as "197 - "Payment adjusted for absence of precert/preauth." 28 Texas Labor Code §134.60 (p)(5)(A)(iv) states in pertinent part, "Non-emergency health care requiring preauthorization includes: … physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: Level I code range for Physical Medicine and Rehabilitation, but limited to: Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; ... and 134.60(p)(7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program;" Review of the submitted documentation finds,

    a. Copy of authorization from mcmc dated January 11, 2013 states, "The service as requested, work hardening 80 hours, CPT codes 97545 and 97546, is medically necessary and appropriate"

    b. No supporting documentation that date of service 96151, for date of service February 12, 2013 was prior authorized.

    The carrier's denial is not supported, except for 96151. Therefore, the disputed services will be reviewed per applicable fees and guidelines.

3. 28 Texas Labor Code §134.204(h)(1)(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR. 28 Texas Labor Code §134.204(h) (3) For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening. (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

    Review of the submitted documentation finds;

    a. The disputed services were billed with CA as second modifier therefore, per Rule 134.204(h)(1)(B) the CPT code 97545 and 97546 is payable at 100% of the MAR or $64.00 per hour/unit. The disputed services are reviewed below.

Date of Service	Units	Submitted Code	Billed Amount	Maximum Allowable Reimbursement	Paid Amount	Amount Due
January 17 , 2013	1	97545 WH CA	$213.50	$64.00 x 1 units = $64.00	$0.00	$64.00
January 17 , 2013	6	97546 WH CA	$640.50	$64 x 6 units = $384.00	$0.00	$384.00
January 18, 2013	1	97545 WH CA	$213.50	$64.00 x 1 units = $64.00	$0.00	$64.00
January 18, 2013	6	97546 WH CA	$640.50	$64 x 6 units = $384.00	$0.00	$384.00
January 31, 2013	1	97545 WH CA	$213.50	$64.00 x 1 units = $64.00	$0.00	$64.00
January 31,	6	97546 WH CA	$640.50	$64 x 6 units = $384.00	$0.00	$384.00

2013						
January 30, 2013	1	97545 WH CA	$213.50	$64.00 x 1 units = $64.00	$0.00	$64.00
January 30, 2013	6	97546 WH CA	$640.50	$64 x 6 units = $384.00	$0.00	$384.00
February 1, 2013	1	97545 WH CA	$213.50	$64.00 x 1 units = $64.00	$0.00	$64.00
February 1, 2013	6	97546 WH CA	$640.50	$64 x 6 units = $384.00	$0.00	$384.00
February 4, 2013	1	97545 WH CA	$213.50	$64.00 x 1 units = $64.00	$0.00	$64.00
February 4, 2013	6	97546 WH CA	$640.50	$64 x 6 units = $384.00	$0.00	$384.00
February 7, 2013	1	97545 WH CA	$213.50	$64.00 x 1 units = $64.00	$0.00	$64.00
February 7, 2013	6	97546 WH CA	$640.50	$64 x 6 units = $384.00	$0.00	$384.00
February 11, 2013	1	97545 WH CA	$213.50	$64.00 x 1 units = $64.00	$0.00	$64.00
February 11, 2013	4	97546 WH CA	$427.00	$64.00 x 4 units = $256.00	$0.00	$256.00
February 12, 2013	4	96151	$140.00	Not supported by copy of prior authorization. Not eligible for review	$0.00	$0.00
		TOTAL	$6,972.00	$3, 456.00	$0.00	$3,456.00

4. The total Maximum Allowable Reimbursement (MAR) is $3,456.00. The carrier paid $0.00. The remaining balance of $3,456.00 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,456.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,456.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 12, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.